

TRANSACTIONS
OF THE
NEW YORK SURGICAL SOCIETY.

Stated Meeting, January 13, 1904.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

COMPLETE EXCISION OF SCAPULA FOR SARCOMA.

DR. LILIENTHAL presented a young girl who had been shown at two previous meetings of the Society. Less than a year ago she developed a round-celled sarcoma of the scapula, which was first treated by means of the X-rays and injections of Coley's fluid. As a result of this treatment there was temporary improvement, followed by a sudden increase in the size of the tumor, and without further delay the entire scapula was excised, leaving only the glenoid cavity. Both the wing and spine of the bone were found to be involved by the sarcomatous process. The wound healed by first intention, and the immediate functional result was excellent. For several months after the operation the injections of Coley's fluid were continued, and subsequently the patient was kept under careful observation. About six weeks ago a soft, movable mass, about the size of a hickory-nut, was felt in the stump of the scapula. This was removed, and proved to be a soft mass directly connected with the bone. The latter was thereupon removed, completing the total excision of the scapula.

Dr. Lilienthal said the case illustrated the importance of very complete excision in cases where bony tissue was invaded. Another interesting feature was the excellent functional result in a case where the entire scapula had been removed so recently. The patient had very good use of the arm, and its function was constantly improving. The speaker thought this might be due to the fact that the operation had been done in two stages.

SUPRAPUBIC PARTIAL PROSTATECTOMY.

DR. F. TILDEN BROWN reported the history of a man, sixty-seven years of age, who was first seen by him in October, 1902. The man was in excellent general health, but for five years had had increasing difficulty in urination, characterized by moderate frequency, always tardiness in starting stream, dribbling, and sense of unemptied bladder at termination. On a few occasions of retention and for examination purposes, different doctors have passed a catheter. Residuum after urination has been from five to ten ounces. On one occasion of retention used catheter himself.

Physical Examination.—Heart negative. Vessel walls slightly thickened. After passing four ounces of clear urine, an easily introduced rubber catheter finds twelve ounces residuum at nine and one-fourth inches urinary distance. Kidney excretions normal, excepting for moderate polyuria.

Rectal examination shows a half-lemon sized prostate. Slight median furrow discernible. Both lobes of uniformly firm, elastic consistency. The right noticeably the larger. Cystoscopy revealed an intravesical collarette, only interrupted by a fissure between the median and smaller left lateral lobes. No cystitis.

Suprapubic operation in September. Gas and ether anesthesia. Moderate Trendelenburg posture. The sheath of the operator's cystoscope, carrying a cold lamp, was passed through the urethra to the bladder. This was used first for irrigation purpose, then for vesical distention before opening the viscus above, and during the remainder of the operation as the source of illumination for the surgical field. The then protruding prostatic lobes, with a moderate fissure between the median and left lateral, resembled a large cervix uteri with a unilateral laceration.

A vertical incision was made with a galvanocautery knife through the mucosa over the larger right lobe, which, with the median, was then enucleated. The presence of the cystoscope in the urethra served to gauge the intervening urethral wall. The left and smaller lobe was not removed, on the ground that by itself no barrier to urination would result, and that any needless traumatism should be avoided.

Bladder drainage was provided for by two small, soft, rubber-angled catheters conjoined at their lateral eyes by a silk

stitch; one led out through the urethra, the other through the suprapubic wound. This simple means was always effective in keeping dressings and bed perfectly dry. When the vesical wound, which had been sutured in the greater part, was ready to close, the catheters were freed by severing their connecting stitch with delicate scissors through the suprapubic wound. The short-angled catheter was then left in the urethra a few days longer. The patient made practically an uninterrupted recovery and left the hospital on the twenty-fourth day after operation. At this time there were between one and two drachms of residual urine. The urinary distance changed from nine and one-fourth inches to seven and three-fourths. The urine was passed in a continuous, forceful stream such as the patient likened to that of his youth. Subsequent examination has never found more than a drachm of residuum. Moderate polyuria persists, and he gets up twice at night for urination.

PERINEAL GALVANOCAUTERY PROSTATOTOMY.

DR. BROWN presented a man, aged seventy-nine years. A well-preserved, vigorous old man except for the exhaustion and depression due to a recently increasing obstructive cystitis. At twenty-two had urethritis; at fifty-five, pneumonia.

About two years ago he began to have frequency of urination; this was gradually augmented and pain became associated. When first seen, in April, 1903, he was obliged to urinate every half-hour night and day. Restful nights were impossible, but he continued to go to business daily. Urine was that of marked acid cystitis. Tuberculosis was excluded. Residual urine was between four and six ounces. Urinary distance, eight and one-half inches. Rectal examination showed prostatic enlargement of triangular shape, laterally. Right lobe two by one and one-fourth inches; left lobe one and three-fourths by three-fourths inches. Interlobular furrow distinct. No nodules. Uniform consistency. Cystoscopy revealed only a moderate intravesical projection of the lateral lobes, but a fairly prominent elevated lip stretching between them. Vesical mucosa showed a high grade of chronic cystitis.

Brief local and systemic treatment was attended with considerable improvement. Patient was not seen then for six weeks. On his return, the former distressing symptoms had recurred.

Against his inclination, he consented to go to the hospital for proper attention and observation; a few days of the latter convinced the speaker that some form of operative interference was indicated. Because of his age and marked mental and physical depression, as well as the high bladder floor and the perineal drainage which his cystitis required, Chetwood's operation appeared to be indicated in preference to perineal prostatectomy. This was done with Dr. Chetwood's valuable assistance on September 3, under gas and ether anesthesia, the patient being in the lithotomy posture. Through an incision entering the membranous urethra the galvanocautery incisor was passed into the bladder. The Chetwood technique was then carried out on each lateral lobe and on the intervening lip or bar. Thereby the floor of the bladder was appreciably lowered. A large, soft rubber perineal catheter was left in the wound until the end of the fourth day. Except for some mental aberration lasting three days, the patient made an uneventful convalescence.

Urine ceased to come through the perineal sinus by the twenty-first day. Urinary intervals were daily increasing and amount of residuum decreasing, so that at the time of his leaving the hospital on the twenty-seventh day after operation this was practically *nil*. The urine then still showed a decided cystitis. At the present time he has regained a degree of health such as he had not known for three years. His urinary intervals are now from four to five hours. There is no residuum whatever. The urine still shows, and probably always will, a colon bacillus cystitis, but with the removal of obstruction it is practically symptomless.

DR. L. W. HOTCHKISS asked Dr. Brown whether he regarded the suprapubic operation on the prostate as a more dangerous procedure *per se* than the perineal method? The question had excited much controversy, and was still, apparently, unsettled. The suprapubic route gave the operator an excellent command of the bladder, and seemed to be the more natural method of entering it, providing, of course, there were no special contraindications.

DR. BROWN, in reply to Dr. Hotchkiss, said his experience with perineal prostatectomy was rather limited. He thought that a freer access to the field could be gained by the suprapubic route, and he was always pleased when there was some element about the case which enabled him to see a possible advantage for the suprapubic operation, in contradistinction to the perineal. The

wonderfully rational technique of the method of perineal prostatectomy that had recently been brought before the profession by Dr. Young had appealed to him, however, both from an anatomical and physiological stand-point; and consequently his first prejudices against this route would in the future be greatly minimized.

DR. LILIENTHAL said he had had considerable experience with suprapubic prostatectomy; and he saw no good reason why he should substitute any other method. He regarded suprapubic prostatectomy as a safe surgical procedure when compared with other similar operations in that region. The method afforded an opportunity of examining the bladder; it rendered possible the removal of encysted stones which could not be removed from below; and at times revealed the presence of a diverticulum or tumor which might otherwise have remained undiscovered. In short, it was beyond question the most surgical method of gaining access to the bladder. With a suprapubic wound for removing the enlarged prostate, he did not think it necessary to make an additional opening through the perineum for the purpose of drainage or anything else. The latter was often more difficult to close than the upper wound. All things considered, he thought it better to leave the bladder wound open, and not make any effort to hasten its closure by suture. In his last case, the suprapubic wound had closed entirely in two weeks, and the patient passed all his urine through the natural passages. In another case he had in mind the wound had closed entirely, and the patient left the hospital in fifteen or sixteen days after the operation. In neither case had any attempt been made to suture the wound in the bladder. His method of opening the bladder was as follows: it was first merely punctured, and then the opening was enlarged by inserting a dressing forceps; this did not actually tear the walls of the bladder, but merely separated them, and they readily recontracted.

Dr. Lilienthal said he was glad to observe that some of the more progressive men had come out squarely in favor of suprapubic prostatectomy. In the January (1904) issue of the ANNALS OF SURGERY, Moynihan, of Leeds, reported twelve cases he had done by the suprapubic method, of which he thoroughly approved. In his article the writer mentioned that in doing the suprapubic operation there was a likelihood of tearing out a part of the pros-

tatic urethra. Dr. Lilienthal said he did not think that accident would occur if the work was not done too hurriedly. It could be avoided by good surgery, and even if the accident did occur it would probably not result in stricture, as the prostatic urethra was of so great a caliber that a section of it could be sacrificed without much harm.

DR. BROWN, in reply to a question as to whether he would again resort to perineal prostatectomy by the Chetwood method in a similar case, said that he would. The patient was an old man, in a very feeble condition as the result of his continued urinary suffering. It was very doubtful whether he could have withstood a prostatectomy. His mental symptoms after the milder operation would probably have appeared in an aggravated form after a severe operation. He was, in short, on the borderline, where any additional strain might have resulted in a fatal issue.

In a more recent case, Dr. Brown said, he had been induced, against his better judgment, to do a perineal prostatotomy by the same method in a case where either a suprapubic or perineal prostatectomy was indicated, but refused by the patient. The result, up to the present time, had not been very encouraging.* This was possibly due, the speaker said, to his inexperience with the Chetwood instrument or to the brief time since the operation, the patient not yet being out of bed.

EPITHELIOMA OF CHEEK: EXCISION AND PLASTIC OPERATION.

DR. IRVING S. HAYNES presented a man, thirty-six years old, with a negative personal and family history, who about a year ago developed an epithelioma of the interior of the left cheek. It measured about an inch and one-half from before backward, and involved practically the entire thickness of the cheek. The lesion was excised, and the gap left in the cheek was closed by the following plastic operation: A tongue-shaped flap was carried up from the neck and inverted, so that its external surface corresponded to the former mucous surface of the cheek. This flap was sutured to the gum above and below, and took very readily.

* Since the above remark, the results now noted, ten days later, justify its retraction, catheter tests showing improvement.

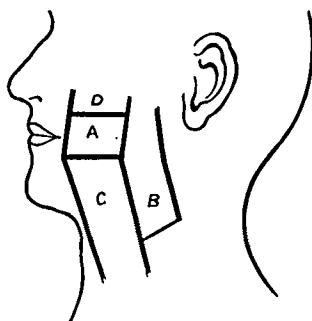


FIG. 2.—Epithelioma of cheek. Excision. Result of plastic operation.

A second flap was then carried up from the neck, and, without inverting it, it was placed so as to cover the outer raw surface of the first flap. After two weeks the base of the inverted flap was excised and turned downward, partially covering the denuded area left from the first operation. All the wounds healed without complication, with the exception of a slight infection, which was probably due to the too energetic use of Balsam of Peru for the purpose of hastening granulation.

Dr. Haynes said that the hairs on the inner surface of the first flap had grown somewhat since the operation, but its surface was beginning to assume the appearance of mucous membrane. The opening into the mouth which had existed until now along the base of this inverted flap was closed.

FIG. 1.



Plastic operation to reform cheek. *A*, Quadrilateral area involving entire cheek excised; *B*, Flap turned into mouth to replace mucous membrane; left attached by its base until union was secured; *C*, Flap slid upward and *D* flap slid downward to cover the raw surface of *B*.

Healing was rapid and the wounds closed, giving a good result without leakage. The diagram shows the direction of the incisions, and the photograph (Fig. 2) the appearance at the time of his discharge. The dark area below the lobe of the ear is a small granulating area, left by raising the flap for the interior of the cheek.

DR. CHARLES H. PECK said that about a year ago he showed to the Society a case of epithelioma of the cheek in which an operation somewhat similar to that of Dr. Haynes was done. The lesion was a very large one, measuring about two and one-quarter by one and seven-eighths inches, and the ulceration had extended

between the buccal folds to their reflections upon the upper and lower jaws. The gap left in the cheek by the removal of the lesion was closed by a flap carried up from the neck, but it was not inverted, as in Dr. Haynes's case. The result was excellent; but there was subsequently a recurrence in the scar, which necessitated a second similar operation, excepting that the flap was carried downward from the forehead. The result of the second plastic procedure was again satisfactory, and death finally occurred from metastases in the lungs.

EPITHELIOMA OF THE TONGUE.

DR. HAYNES presented a man, forty-seven years old, who four months ago first noticed a small pimple on the left edge of the tongue. It gradually increased in size, and on December 11 last he had a severe hemorrhage caused by ulceration of the process through the terminal branch of the lingual artery. The bleeding was so severe that it was only controlled by passing a mattress suture through the tongue. Subsequently, the anterior two-thirds of the tongue were removed, the excision being preceded by ligation of both external carotids. At the time of the operation the left submaxillary gland, which was somewhat enlarged, was also removed. The stump of the tongue was drawn downward and anchored to the floor of the mouth by means of a deep mattress suture passed through the tongue and floor of the mouth and tied just behind the symphysis so as to cover the large raw surface that remained. Healing had been satisfactory. The man could make himself understood without difficulty.

DR. E. W. GWYER said that a few years ago he had a case of epithelioma of the tongue in which he excised the lateral half of the organ, and then curved the tip of the remaining portion around to the base and stitched it in that position, so that it resembled a parrot's tongue. This gave an excellent result, so far as the power of speech was concerned. A recurrence took place after one year.

LYMPHATIC CONSTITUTION; CARE OF THE LYMPHATICS DURING AND AFTER OPERATIONS.

DR. F. W. GWYER read a paper with the above title, for which see page 641.

DR. JOSEPH A. BLAKE said that a few years ago he read a

paper upon this subject, and had reported seven cases. In three of these death had occurred under ether anæsthesia;—in one under chloroform and in three no anæsthetic had been given. Although the presence of an enlarged thymus was not absolutely essential in this condition, it was of considerable corroborative significance; in fact, all these cases were regarded as instances of thymus-death before the general lymphatic condition was understood. The condition of the spleen was also of importance.

Dr. Blake said that in the extirpation of tuberculous glands in the neck or axilla he could recall a number of instances where prolonged manipulation was followed by hyperpyrexia and even by death. In operating on these cases, he preferred a free dissection, similar to that employed in the removal of malignant growths. By the usual method, with blunt dissection, the glands were manipulated a great deal, and their contents squeezed into the general circulation; and this, the speaker thought, caused the infection and evanescent temperature.

Dr. LILIENTHAL asked Dr. Gwyer how he sterilized the vaseline that he injected into abscess cavities and applied externally before operating for empyema. Personally, he had always been inclined to believe that vaseline, once infected, could not be rendered sterile by boiling without burning it.

Dr. GWYER replied that he sterilized the vaseline by boiling it for about fifteen minutes over a water-bath. It was then put in collapsible tubes of good size and was ready for use, keeping sterile indefinitely.

Dr. IRVING S. HAYNES said he had come to the conclusion that in children under four years of age ether was a safer anæsthetic than chloroform, in spite of the fact that the use of the latter was particularly advised by the text-books in those patients. He recalled four cases where the use of chloroform in children under four years of age nearly resulted fatally in his hands. In older children and adults, where there were no contraindications, he preferred chloroform.

Dr. BLAKE said that the report of the committee appointed by the British Medical Association showed very clearly that chloroform was most dangerous during the first decade of life. This was contrary to the general impression held by the profession. The proportion between the number of chloroform and ether

deaths was much greater before than after the age of ten, and favored the latter anæsthetic.

DR. GWYER, in closing, said he did not wish to have it inferred from his paper that he favored blunt dissection in all cases and at all times, but he thought that the sharp and clean dissection method should not be used exclusively; that there was a place for both in the technique of operations.

STRANGULATED PARTIAL ENTEROCELE THROUGH THE OBTURATOR FORAMEN.

DR. LUCIUS W. HOTCHKISS said that at one of the recent meetings of the Society he had read a paper on this subject in which he reported five cases of Littre's hernia, including both the femoral and inguinal variety. The specimen he now showed was of the obturator variety, and was not recognized before death. The patient was a German woman, seventy-one years old, who was admitted to the J. Hood Wright Memorial Hospital on December 26, 1903, at 2.40 P.M. For a long time she had suffered from cough, and about ten years ago she first noticed a hernial swelling in the left groin. Two days before her admission she began to suffer from abdominal cramps, and twenty-four hours later persistent vomiting had set in. The bowels had not moved for three days, despite purgatives and enemata, and the abdomen had become considerably swollen. Prostration was marked, the body surface cool, pulse feeble and rapid. Temperature was 99.4° F.; pulse, 112; respirations, 40. An examination of the blood showed 8400 white cells. The urine was negative.

An examination of the abdomen showed that the distention was more marked over its lower half; it was tympanitic and moderately tender. In the left groin there was a reducible inguinal hernia about the size of a lemon. The patient was immediately given a high enema containing turpentine and glycerin; this resulted in a large, constipated movement, with much gas. The pain was temporarily relieved. At 8 P.M. the same day the enema was repeated, with a satisfactory result. During the night, however, the patient grew worse, and by morning her temperature had risen to 103° F.; pulse, 110. The pain was more severe. The patient was vomiting and evidently sinking. At 4 P.M. her temperature was 106.8° F.; pulse imperceptible. She died at 4.30 P.M. on December 27, the day after her admission.

Autopsy.—The peritoneal cavity contained about ten ounces of bloody serum. The intestines were injected and the ileum markedly distended down to a point fifty inches from its lower extremity. At this point the gut passed into the obturator foramen on the right side, and below it was collapsed to the ileocaecal valve. The obturator hernia was reduced by moderate traction, and found to be a partial enterocele, comprising about one-half the circumference of the gut, which was strangulated and minutely perforated. A well-defined sac was found, acutely inflamed and containing about four cubic centimetres of a stinking, brownish fluid. The sac was adherent to a mass of fatty tissue.

TORSION OF THE UTERUS.

DR. JOHN F. ERDMANN presented a specimen obtained from a widow, fifty years of age, who gave the following history: She had passed the menopause five years ago. During her early married life she had had three miscarriages, but had never gone on to complete pregnancy. Last August she had an attack of abdominal pain, accompanied by considerable shock, which lasted three days. Some eight months ago she had a second similar attack, lasting two days, and her third attack came on a week ago. When Dr. Erdmann saw her in consultation last Sunday afternoon, she had been suffering for two and one-half days; there were considerable collapse and a temperature of 102° F.; pulse, 126. The abdomen was much distended, and there was a sense of fluctuation over the left side. The condition was regarded as a large uterine fibroid with a twisted pedicle, or an ovarian cyst. Upon opening the abdomen he found that he had to deal with a torsion of the uterus, with its pedicle twisted two and one-half times from right to left. He could not at first make out what this pedicle consisted of, but later, upon investigating, it proved to be the cervix elongated and attenuated. The organ was removed *in toto*, together with its appendages, and the patient made an uneventful recovery.